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FISCAL IMPACT STATEMENT

LS 6935
BILL NUMBER: SB 406

NOTE PREPARED: Feb 27, 2014
BILL AMENDED: Feb 27, 2014

SUBJECT: Medicaid False Claims.

FIRST AUTHOR: Sen. Mishler
FIRST SPONSOR: Rep. Clere

BILL STATUS: 2nd Reading - 2nd House

FUNDS AFFECTED: X GENERAL
DEDICATED
X FEDERAL

IMPACT: State

Summary of Legislation: (Amended) This bill makes certain procedural changes to the False Claims Act and Medicaid False Claims Act to remove inconsistencies and comply with federal law.

CHOICE Program: Beginning January 1, 2015, the bill changes asset limitations within the Community and Home Options to Institutional Care for the Elderly and Disabled Program from $500,000 to $250,000 and specifies certain exemptions. Beginning January 1, 2015, it requires annual adjustment of the asset limitation using the federal Consumer Price Index.

Beginning January 1, 2015, the bill allows a participant who is unable to perform at least one activity to participate in the program under specified circumstances.

The bill requires the Division of Aging (DoA) and the Area Agencies on Aging (AAAs) to jointly establish specified procedures. Beginning January 1, 2015, it allows the DoA to: (1) annually redetermine program eligibility; and (2) place a lien to recoup the cost of program services that exceed $20,000. The bill also requires the DoA to exclude $20,000 of countable assets in determining cost participation for the program.

Medicaid Single State Agency Provisions: The bill designates the Office of the Secretary of Family and Social Services (FSSA) as the single state agency for the administration of the Medicaid program and removes the designation from the Office of Medicaid Policy and Planning (OMPP).

Indiana State Department of Health Provisions: The bill repeals the law concerning the Health Care Facility Advisory Council. It transfers certain duties of the council to the Indiana State Department of Health (ISDH).

The bill changes the amount of time from 4 years after birth to 12 months after birth that a birth certificate presented for filing is considered a delayed certificate of birth. It requires a diagnosis of autism at any age to be reported to the Birth Problems Registry. (Current law provides for the reporting of an autism diagnosis made before a child's fifth birthday). It also adds certain visual impairments to the definition of birth problems for purposes of reporting to the Birth Problems Registry.

The bill also requires the FSSA to provide reports of a child's vision impairment diagnosis to the ISDH for inclusion in the Birth Problems Registry.

The bill allows not more than 50% of the monies in the spinal cord and brain injury fund to be used to develop a statewide trauma system.

Before September 1, 2014, the bill requires the ISDH to: (1) adopt rules concerning the regulation of facilities for treatment of traumatic brain injuries; and (2) make recommendations to the Legislative Council and Health Finance Commission concerning food handling law changes.

The bill adds insulin to the definition of "legend drug" and provides that insulin may be sold for retail sale by a pharmacy only to an individual who possesses a prescription from certain practitioners.

Effective Date: Upon Passage; July 1, 2014, January 1, 2015.

Explanation of State Expenditures: *FSSA Provisions:*

Medicaid Single State Agency Provisions: These provisions have no fiscal impact.

(Revised) *Reporting Requirements:* The required provision of copies of provider reports concerning individuals who have been diagnosed as legally blind or with visual impairment that interferes with the individual's functioning in school, employment, or activities of daily living to the Birth Problems Registry should be accomplished within the level of resources currently available to the FSSA. (Current law provides that these reports may be furnished to the ISDH upon request.)

Indiana State Department of Health Provisions:

Spinal Cord and Brain Injury Fund Provision: The bill would expand the purposes for which money in the fund may be spent to include the development of a statewide trauma system and allows up to 50% of money in the fund to be used for this purpose. Money in the dedicated, nonreverting fund comes from a $0.30 fee included on passenger car and motorcycle registrations. Money in the fund is administered by the ISDH and is continuously appropriated for the purpose of the fund. Annual fund revenue averages about $1.6 M. Up to $800,000 would be available annually for statewide trauma system development. The balance in the fund as of June 30, 2013, was approximately $4.2 M. Up to 50%, or $2.1 M, would also be available for trauma system development.

The bill would also repeal the Health Care Facility Advisory Council. Members were not appointed to the Council, and the Council has never met. The provisions concerning the expansion of the Birth Problems Registry reporting requirements may require a rule revision. Rule revisions are considered to be administrative functions that should be able to be performed within the level of resources available to the ISDH. The provision concerning the period of time that a delayed certificate of birth may be filed with local health officers may increase the number of late filings of birth certificates processed by the ISDH. The

increase would likely be small and should be able to be accommodated within the current level of resources available. Provisions requiring a report to the legislature and the promulgation of rules adding a new licensure category are routine administrative functions of the ISDH that should be accomplished within the existing level of resources available to the agency.

Insulin Provision: State employee high-deductible health plans may be affected to the extent that individuals currently may attempt to manage health care expenses by using over-the-counter (OTC) insulin products instead of submitting claims for higher-cost legend products. If the bill reduces the financial incentive for using OTC insulin products, insured individuals with high-deductibles may choose to use more expensive products - ultimately resulting in higher pharmaceutical claims. FSSA reported that adding insulin to the definition of legend drug would have no anticipated effect on the Medicaid program since all covered drugs currently require a prescriber's order or prescription. The reimbursement methodology for the cost of insulin is the same, whether the order is for OTC or legend products.

CHOICE Program- Summary: The fiscal impact of the CHOICE provisions of the bill would be limited by the level of the appropriation. Eligibility expansion provisions may increase the demand for CHOICE services while administrative and cost participation provisions may result in fewer dollars for the provision of services by shifting more expenditures to administrative functions and decreasing collections from cost participation requirements.

Additional Information:

CHOICE Eligibility Expansion: The fiscal impact of this provision would be limited by the level of the appropriation. The bill would allow individuals unable to perform one activity of daily living (ADL) or some activity to qualify for CHOICE services if the AAA determines that addressing the deficit or providing targeted intervention or assistance would significantly reduce the likelihood of the loss of independence and the need for additional services. The cost of this provision would depend on the extent to which the AAAs may already be providing services for persons unable to perform one ADL. (The 2010 *CHOICE Annual Report* identified that services were provided to 571 persons with one documented ADL. These may have been only case management services.) The CHOICE program also currently provides Medicaid waiver recipients services that are not covered under the waiver.

Case Management Services: The bill provides that the DoA and the AAAs are to jointly determine the percentage of program funding that is adequate to provide case management services for the CHOICE program. Case management dollars currently are allocated from Title III B federal funding (Supportive Services and Senior Center Programs), the CHOICE appropriation, and the Social Security Block Grant allocation. The fiscal impact of this provision depends on any actions implemented with regard to the allocation of program funds for case management services. Since CHOICE funding is limited by the level of the appropriation, any increase in dollars allocated to case management would require a corresponding decrease in dollars available for the provision of other services.

Income and Asset Determination: The bill includes the verification of an applicant's income and assets in the definition of case management. Currently, CHOICE applicants are expected to apply for Medicaid if they are not already receiving Medicaid assistance or have not applied within the last 90 days. DoA has reported that sometimes CHOICE applicants are given an expedited Medicaid denial if their resources are clearly over the Medicaid limits. After January 1, 2015, the bill restricts a CHOICE initial applicant's assets to $250,000 as adjusted by the Consumer Price Index (CPI) and further specifies that only assets that are included in the

Medicaid determination may be used for the CHOICE program. (The most common Medicaid asset exclusion is the principal home and automobile in determining available assets.) The bill excludes CHOICE recipients from Medicaid look-back requirements concerning the transfer of assets - applicants could divest themselves of excess assets and qualify for CHOICE services at any time. It is not clear if the Medicaid spousal impoverishment provisions, which allow for a higher level of income and assets for the support of a community spouse, would be included as a provision of the CHOICE program. The lower level of assets allowable would only apply to new applicants. Current participants would be unaffected by the lower standards. This provision would have an indeterminate fiscal impact to the extent that current CHOICE participants may have countable assets in excess of $250,000. The bill would also allow a redetermination at the DoA's discretion. DoA has reported that there is currently an annual eligibility redetermination process in place for the CHOICE program. DoA has further reported that CHOICE asset determination is done on the basis of self-declaration by the client. The value of a primary home and automobile are not included in the level of assets considered. No further actions are taken to verify the client's information outside of the Medicaid application process conducted by the Division of Family Resources. Increasing the level of required asset verification as well as the use of different standards for participants based on application dates will require an increased level of administrative resources. More administrative complexity may result in fewer dollars available for provision of services.

The bill requires the DoA and the AAAs to jointly establish a client needs-based assessment tool and performance standards for the AAAs. The bill also establishes an annual process to increase the asset limitation by the CPI and requires the result to be published in the *Indiana Register* each year. These requirements would be administrative duties that should be able to be accomplished within the resources available to the DoA. Application of the CPI to the asset limitation of $250,000 could potentially allow more individuals to qualify for CHOICE services. However, the fiscal impact would depend on the structure of the cost participation formula. If the treatment of assets within the cost participation schedule is also indexed to the CPI, collections of cost participation could offset any increase. Since the allowable Medicaid asset limitations are not changed, it will do nothing to allow more individuals to qualify for the Medicaid waiver services for which state funds can be leveraged with 67% federal funds.

Cost Participation: The fiscal impact of changes to the cost participation schedule is indeterminate. The DoA and the AAA administrative process to determine the revised cost participation should be accomplished within the current level of resources available. The bill requires the DoA and the AAAs to jointly establish a cost participation schedule based on CHOICE participants' income and assets. The bill requires that the first $20,000 of assets should be disregarded in the determination of the cost share. The bill would remove the current statute establishing a client cost share for individuals with incomes above 150% of the federal poverty level (FPL), replacing it with a requirement that individuals with income and countable assets that do not exceed 150% of the FPL are excluded from the cost-share requirement. The effect of this language is unclear since the FPL does not include assets - only income. The bill would require that individuals with income and assets above 350% FPL would be required to participate at 100% of the total cost of services. Medical expenses that would cause an applicant's available income to drop below the 150% threshold are also disregarded. (Most sliding fee scales and the calculation of FPL are based solely on income.)

Collections of Cost Share: For FY 2013, 253 CHOICE clients with incomes over 150% FPL were billed an average cost share of 18%, or $174,400, for services costing $968,400. DoA reported that 87% of the billed cost share was collected, or $151,900. Cost share collected by the AAAs can be used to purchase more CHOICE services.

Uncompensated Care: The bill requires the Area Agencies on Aging to determine the savings realized due

to services provided by a person, such as a relative, who is not compensated for the care. Of the savings attributable to uncompensated care, 20% is to be allocated to the reduction of the individual's cost share, if any. Since no dollars are currently allocated for care that is not compensated, the impact of this provision would be a reduction in the amount of cost share collected. There are no data available to determine the level of uncompensated care that may be provided to individuals that currently have a cost share or who will have a cost share in the future. The loss of cost share dollars collected could range from $0 - $151,900. These dollars are currently available to the AAAs to provide services for other individuals within the CHOICE program.

Liens: The bill would allow the DoA to place liens on property to recover the cost of CHOICE services provided in excess of $20,000. The fiscal impact of this provision is indeterminate and depends on individual circumstances.

Currently, CHOICE eligibility standards include the following: (1) 60 years of age or disabled; (2) no income restrictions - cost share is required for anyone above 150% of FPL; (3) assets under $0.5 M; (4) unable to perform two or more assessed ADLs.

In 2011, 90% of CHOICE clients reported annual incomes under $25,000. This level of income is under 220% of the 2013 FPL for an individual, or 160% of the 2013 FPL for two persons.

Current Medicaid waiver eligibility standards include the following: (1) 65 years of age or disabled; (2) income level must be at or under 300% of the SSI standard; (3) assets under $1,500 for singles and $2,000 for a couple (excepting that spousal impoverishment provisions apply); (4) unable to perform three or more ADLs. Currently, 300% of the 2014 SSI standard for an individual is $25,956, and $38,952 for two persons.

Explanation of State Revenues: *Insulin Provision:* Including OTC insulin products as a legend drug will have no impact on state sales tax collections since insulin products for medical purposes are specifically exempted from the sales tax.

Medicaid False Claims Act: The bill will bring the state Medicaid False Claims Act into compliance with the Federal Deficit Reduction Act of 2005 (DRA). If the state statute meets requirements of the DRA, the state is allowed to keep a 10% larger percentage of any Medicaid false claims recovery than it normally would. The state's current Federal Medical Assistance Percentage (FMAP) is about 33%. With a DRA compliant statute, the state could retain 43% of any funds recovered.

In CY 2013, the Medicaid Fraud Control Unit recovered over $52 M. The federal share of the recoveries was $32.1 M; the state share was $19.9 M, or about 38.3%, so some portion of the 2013 recoveries included Deficit Reduction incentive dollars.

Additional Information: Indiana first passed its False Claims Act in 2005, so the state is not eligible for the Deficit Reduction incentive on claims involving years prior to 2005. In addition the state FMAP share varies from year to year. As claims from years prior to the enactment of the Indiana False Claims Act become past the statute of limitations, the Deficit Reduction incentive will become a larger percentage of the state recoveries.

Explanation of Local Expenditures: *Vital Statistics Provisions:* The bill would shorten the period of time a certificate of birth may be filed with local health officers. This provision may decrease the number of birth

certificates local health officers process. The decrease would likely be small.

Insulin Provision: Local units of government employee health plans may be affected to the extent that individuals currently attempt to manage health care expenses by using OTC insulin products instead of submitting claims for higher-cost legend products. Employers with high-deductible health insurance plans may be more likely to be affected by a change in the definition. [See *Explanation of State Expenditures* above.]

Township trustees are required to provide insulin for indigent individuals. If OTC products are currently being used by an individual, trustees may incur additional costs related to obtaining a prescription.

Explanation of Local Revenues:

State Agencies Affected: Attorney General; Family and Social Services Administration, DoA; ISDH.

Local Agencies Affected: Local units of government; Township trustees; Local health officers.

Information Sources: Attorney General's Office, and "State False Claims Laws and Compliance with the DRA: What is Required After FERA and PPACA?" Kirsten V. Mayer, John J. Reynolds, III, Joshua A. Cippel, Ropes & Gray LLP, Boston, MA. at: http://www.ropesgray.com/~/media/Files/articles/2010/05/mayer-reynolds-cippel-author-article-for-aba-national-institute-on-the-civil-false-claims-act-and-qui-tam-enforcement.pdf ; ISDH, and the Auditor of State's data; *Indiana Handbook of Taxes, Revenues, and Appropriations, FY 2013*, Legislative Services Agency, Office of Fiscal and Management Analysis. Indiana Code; I.C.6-2.5-5-19, Sales Tax exemption; FSSA; IC 12-10-11-8(11); CHOICE Annual Reports for 2010 - 2013. CHOICE Board Minutes - 2013, State Budget Agency Reversion Reports from FY 2012 and FY 2013. CHOICE Cost Share Billed for Billing Dates 7/1/2012 - 6/30/2013, Billings actually generated. Health Management Associates, "CHOICE Program Evaluation, February 1, 2013", Presented to FSSA, Division of Aging, and AARP of Indiana.

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